



## Records Release To Wilson Pediatrics (Transfer Out)

If you have any difficulties obtaining your records, please contact our front desk staff.

Parent or Guardian: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip: \_\_\_\_\_

Cell#: \_\_\_\_\_ Work# \_\_\_\_\_ Home Phone# \_\_\_\_\_

Email: \_\_\_\_\_

Children's Names:

1. \_\_\_\_\_ DOB: \_\_\_\_\_

2. \_\_\_\_\_ DOB: \_\_\_\_\_

3. \_\_\_\_\_ DOB: \_\_\_\_\_

Reason for transfer: \_\_\_\_\_

I authorize: (Name of previous physician) \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

to release medical information from my medical record to:

Name : \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_

for the purpose of review/examination. I further authorize you to provide copies as requested and indicated to the limitations below:

Substance Abuse Yes:      No:

Psychiatric/Mental Health Information Yes:      No:

HIV Information Yes:      No:

This authorization will automatically expire on year from the date signed.

I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

OFFICE USE ONLY

Date Received: \_\_\_\_\_ Records Sent By: \_\_\_\_\_ Date \_\_\_\_\_